DOCUMENT RESUME

ED 426 614 FL 025 659

AUTHOR	Tebble, Helen
TITLE	Medical Interpreting: Improving Communication with Your Patients.
INSTITUTION	Australian National Languages and Literacy Inst., Deakin.
ISBN	ISBN-0-7300-2483-0
PUB DATE	1998-00-00
NOTE	67p.; Accompanying videotape not available from EDRS.
PUB TYPE	Guides - Non-Classroom (055)
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	Certification; *Communication Skills; Consultants; Contracts; Employer Employee Relationship; English; Ethics; Foreign Countries; Helping Relationship; Information Seeking; Interpersonal Communication; Interpersonal Competence; *Interpreters; *Interpretive Skills; Interviews; Language Role; Languages; *Medical Case Histories; Memory; Occupational Information; *Physician Patient Relationship; Pronouns; *Questioning Techniques; Skill Development; Sociocultural Patterns; Translation
IDENTIFIERS	Australia; Turn Taking

ABSTRACT

The guide is designed for physicians and other medical practitioners who need to work with medical interpreters to improve communication with patients. Special attention is given to the Australian context. An introductory section discusses the need for medical interpreters and explains the guide's organization. Subsequent sections address these issues: finding the appropriate medical interpreter and creating conditions for effective interpreting; briefing the interpreter; handling greetings and introductions in the interpreting situation; explaining contracts and related ethical issues; addressing the patient (maintaining eye contact, speaking directly, using pronouns appropriately, taking roles, using names); taking turns at talking; taking the medical history; summing up the physician's diagnosis; and debriefing the interpreter concerning the patient's sociocultural/religious background, attitude, and language use. Appended materials include Australian criteria for certification of interpreters, notes on the English pronoun system, and a briefing checklist. (Contains 22 references.) (MSE)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

A resource for the professional development of medical practitioners

ED 426 614

Medical Interpreting

Improving communication with your patients

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

Joseph Ho Bianco

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

1

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

Helen Tebble

LANGUAGE AUSTRALIA

BEST COPY AVAILABLE

2

Medical Interpreting

Improving communication with your patients

Helen Tebble

LANGUAGE AUSTRALIA
The National Languages and Literacy Institute of Australia

DEAKIN UNIVERSITY

Supported and funded by Language Australia Limited: The National Languages and Literacy Institute of Australia, Australian National University, Canberra, ACT 0200, Australia

© Language Australia Limited: The National Languages and Literacy Institute of Australia 1998

Published by Deakin University, Geelong, Victoria 3217, Australia

First published 1998

Designed, produced and printed by Learning Resources Services, Deakin University

ISBN 0 7300 2483 0

Acknowledgments

Extracts from interpreted medical consultations reproduced by permission of the participants.

Contents

List of abbreviations and acronyms vi

List of conventions for presentation of authentic spoken language vi

Preface vii

Introduction: Why use an interpreter for medical consultations? 1

About this book 2

What is a medical interpreter? 3

Professional interpreters 3

How do you find medical interpreters? 4

Which language? 5

Listening demands on the interpreter 6

Briefing the interpreter 7

Scenario: A sample briefing session 9

Greetings and introductions 11

Remembering names 11

Seating or positioning arrangements 11

The contract 15

Explaining the contract 15

Ethical components of the contract 16

Addressing the patient 19

Maintain eye contact appropriately 19

Speak directly to your patient 20

Pronouns 20

Roles 22
Names 23

Turns at talk **26**
Types of turns 26
Length of turns 26
Modes of interpreting 27
Plan ahead 28
Overlapping 28

Taking the medical history **30**
Types of questions 30
Directing the patient to tell 32
Checking your understanding 33

The exposition **35**
Topics and subtopics 36
Scenario: The consultant physician's summing up 36

Debriefing **43**
Patient's sociocultural and religious background 43
Attitudes 44
Patient's language 44
Summary 44

Conclusion **45**

Appendixes **49**
Appendix 1: NAATI levels of accreditation for interpreters and translators 49
Appendix 2: The pronoun system in English 51
Appendix 3: Briefing checklist 53

Suggested further reading **55**

Dedication

to Skender Bregu and Adolfo Gentile
who initiated me into the fields of
Interpreting and Translating

Abbreviations and acronyms

AUSIT	Australian Institute of Interpreters and Translators
AUSLAN	Australian Sign Language
CHIS	Central Health Interpreter Service Inc.
Level 3	Former term used for current NAATI Accreditation Level of Professional Interpreter
NAATI	National Accreditation Authority for Translators and Interpreters
NHMRC	National Health and Medical Research Council
NLLIA	National Languages and Literacy Institute of Australia
RACP	Royal Australian College of Physicians
TIS	Translating and Interpreting Service (Major Telephone Interpreting Service)
VITS	Victorian Interpreting and Translating Services
Wh–	Question words normally starting with the letters 'Wh–', e.g. 'what'

Conventions for presentation of authentic spoken language

Capital letters	= stressed syllables or sounds
+	= untimed brief pause
=	= no pause between turns at talk
.hhh	= breathing in
hhh.	= breathing out
ni:ght	= sound is lengthened

Normal conventions of punctuation are not used.

Preface

Australia is unique in having a national accreditation system for its translators and interpreters whose main work is in community interpreting. Medical interpreting is part of this work. Communicating with non-English speaking patients without knowing their language is extremely difficult. Having qualified and accredited medical interpreters makes such communication possible. To work effectively with a professional medical interpreter requires the medical practitioner to have developed some specialised skills and strategies.

This book, *Medical Interpreting: Improving Communication with your Patients*, and its accompanying videotape are designed for medical practitioners, to offer them strategies for improving the effectiveness of their consultations with patients whose languages they do not speak. The resources have been developed for use by all medical practitioners—whether they are beginning their careers, undertaking postgraduate studies, or are practising specialists and consultant physicians—particularly if they have not been instructed in how to work with interpreters.

By viewing the videotape, reading the book and relating the material to their own practice of medicine, users of these resources will be able to increase their linguistic awareness, reflect on their own language use and discover ways of improving their communication with their non-English speaking patients when they talk to them through the services of accredited interpreters.

Background

Medical Interpreting: Improving Communication with your Patients, the book and the videotape, are two of the outcomes of a major research project that investigates the nature of interpreting for non-English speaking patients and their physicians and attempts to provide a theory of medical interpreting within the scope of Applied Linguistics.

The research was conducted through the Centre for Research and Development in Interpreting and Translating at Deakin University in conjunction with the Monash Medical Centre and the Southern Healthcare Network of Victoria. The orientation of the research is within the field of Linguistics in the Workplace and, in this case, Linguistics of the Professions. This branch of Applied Linguistics is the area of specialisation offered in Linguistics at Deakin University. The outcomes of the research have relevance to theoretical and Applied Linguistics, the Interpreting and Translating profession and the medical profession, as well as patient education. This book and its accompanying videotape address the medical profession.

The data for the research were drawn from video-recorded, authentic interpreted medical consultations conducted by consultant physicians, specialist physicians, and medical practitioners training to become consultant physicians. Findings from the research reveal that more stages occur in the consultations than is usually acknowledged in the literature on doctor–patient communication; some of these are highlighted in the book and video; others are findings which relate to important communication strategies.

Relevant findings have been selected from the research videotapes for use in this videotape, and excerpts from various consultations have been quoted in the form of transcriptions in the book. In both cases the selections demonstrate strategies for medical practitioners to use when communicating via an interpreter with their non-English speaking patients.

Acknowledgments

Without the people who contributed to the research, the video and book could not have been produced. Thank goodness for the insight of Professor Mark Wahlqvist, Head, Department of Medicine, Monash University, who declared in 1997, 'Linguistics is relevant to medicine!'. His moral support has been substantial, along with the support of Senior Administrators and Ethics Committee staff at the Monash Medical Centre and Southern Healthcare Network in Melbourne, who provided me with access to a most suitable hospital in which to conduct the research. Dr Phil Rosengarten, Director of the Centre for Research in Postgraduate Medical Education in the Department of Medicine at Monash University, was helpful in providing me with facilities for a period of my outside studies program in 1996.

The research has been supported by a number of grants from Deakin University and an Australian Research Council equipment grant. I particularly acknowledge the support of Joseph Lo Bianco, Director of

Language Australia Limited: The National Languages and Literacy Institute of Australia, for the grant to write this book and produce the videotape.

I gratefully acknowledge the support and feedback I have had from colleagues on the Board of the NLLIA Centre for Research and Development in Interpreting and Translating at Deakin University; from members of the Victorian Executive and the National Executive of AUSIT (including the support from NAATI via AUSIT in the early days of the research); from David Connor of AUSIT who has been very helpful in the recruitment of participants for the research; and from AUSIT members, whose enthusiasm, interest and participation in the project has made the research happen. I do thank those interpreters who so willingly participated in the research; the doctors and patients who were prepared to have their consultations recorded and analysed in the cause of improving doctor–patient communication; and the team of transcribers and translators who helped prepare the data for analysis. Vivian Pagorelias made a significant contribution in this regard.

For their time, advice and support, I acknowledge with thanks the nurses, doctors (especially Professor Mal Horne), interpreters, clerical and maintenance staff, and the Anglican Chaplain at the Monash Medical Centre; Marianne Bridge for her feedback on matters to do with AUSLAN; colleagues in Scandinavia, Italy, UK, Canada, USA and Japan for their intellectual support; Valda Dascal for her useful insights into the concept of the 'contract'; and Dr Michelle White, for useful feedback on drafts.

For the production of both the research tapes and the present videotape, I thank Adrian Barker (who commenced the video production) and Mal Paul and his team from Deakin University's Learning Resources Services, as well as John Cooper for his sound recording expertise for the research tapes. In converting some of the research findings that are directly applicable for medical practitioners, I acknowledge the help of my excellent editor and scriptwriter, Jane Cameron, and designer David Williams.

Other colleagues of special significance are Sister Nooi Yeap, whose recruitment efforts and willingness to share her facilities contributed substantially to the project; and Sandra Nestoridis, Chief Interpreter at the Monash Medical Centre and the Southern Healthcare Network, whose recruitment of participants and major involvement in and commitment to the project have been a most generous contribution.

Adolfo Gentile, Chairman of the NAATI Board, and as my former Head of Department and Foundation Director of the Centre for

Research and Development in Interpreting and Translating, supported my research grant applications, provided all the support systems that he could to facilitate the research, and provided very useful feedback on the script and manuscript.

Final and very special thanks go to my medical colleague, Professor Barry McGrath, who has enabled all the video recording to be done, participated as a subject, helped recruit other participants, provided feedback on the script and manuscript, enabled a pilot videotape to be used for feedback and supported the project in every way from the outset. I thank him for helping me investigate an almost-unexplored aspect of doctor–patient communication.

Helen Tebble
Melbourne, June 1998

Introduction: Why use an interpreter for medical consultations?

Simply knowing two languages does not qualify anybody to serve as an interpreter. Old practices of asking relatives and friends of the patient or even hospital cleaners to interpret for the patient and doctor can be dangerous, because in such circumstances, there is no guarantee that what the doctor or the patient say is interpreted at all, or if it is, that the interpreting is done accurately, fully or in confidence.

Relatives and friends may have their own agenda about the patient's treatment and so interpret only what they want to, not what you or the patient say. Younger relatives of the patient may not comprehend the issues involved and thus provide inaccurate or incomplete interpretations. Patients may feel inhibited or embarrassed about describing their symptoms to relatives or friends, so the medical practitioner is deprived of sufficient information to make an adequate diagnosis. Similarly, the friend or relative may feel embarrassed about what the patient has said and not tell everything in English. In addition, the friend's or relative's command of one or both languages may not be enough to relay exactly what has been said by the doctor or the patient. So using an interpreter who is unqualified and not accredited is fraught with danger: the message can be distorted, incomplete, inaccurate, with no guarantee of confidentiality—hardly the quality of information needed for good medical practice.

Medical practitioners and their patients who do not speak the same language can expect to get the best out of their consultations when they use the services of a qualified and accredited interpreter. After all, in medical consultations the health, wellbeing and sometimes even the survival of the patient is at stake, let alone the work satisfaction and legal obligations of the medical practitioner.

The large immigrant population, as well as indigenous people who do not have a strong command of English but who from time to time

need to consult medical practitioners, can now in most cases have the services of an interpreter. This means that medical practitioners can conduct their consultations with non-English speaking patients knowing that what they say is communicated, and that the medical ethics of confidentiality are maintained.

About this book

To effectively conduct a consultation in which two languages are involved requires the medical practitioner to acquire some additional communication strategies and to increase his or her understanding of this special type of communication: interpreted dialogue. This book offers the hospital medical officer and other medical professionals opportunities to consider and use the most important strategies for working effectively with medical interpreters.

Given that members of the medical profession are assigned different labels at various stages of their career, the more general terms 'doctor' and 'medical practitioner' are used for easy reference in this book.

The material is drawn from a major research project on the linguistic and communicative nature of medical interpreting, conducted by the NLLIA Centre for Research and Development in Interpreting and Translating at Deakin University in collaboration with staff and patients of the Monash Medical Centre, Southern Health Care Network.

This book is designed to be used flexibly in conjunction with the accompanying videotape, *Medical Interpreting: Improving Communication with your Patients*. Medical practitioners may prefer to use the videotape and book for their own private study, or to work in a group (with or without a facilitator) using both the video and book. Each section of the book reviews and extends a corresponding videotape segment, and most sections contain activities which may be used as group discussion topics or for individual explorations of practice.

The videotape, whose contents are drawn from authentic consultations, can be viewed first, either all at once, or a section at a time to allow learners to cover the corresponding content and activities in the book. One useful way for individuals to use the material would be to view the videotape first, then read the book and work through the activities, and conclude with a replay of the videotape.

What is a medical interpreter?

A medical interpreter is normally a qualified, accredited, professional interpreter whose work is to convey to the patient in his or her language what you say to the patient in English and vice versa. *Interpreters* deal with the spoken word while *translators* deal with the written word. Some people are accredited as both interpreters and translators.

Use a professional interpreter for unbiased, complete and accurate interpreting.

Professional interpreters

A medical interpreter is a professional who has the following credentials:

- national accreditation as an Interpreter with NAATI, the National Accreditation Authority for Translators and Interpreters (formerly and still popularly known as NAATI Level 3); and subscribes to a code of ethics of the Australian Institute of Interpreters and Translators;
- is qualified as a professional medical interpreter, for example by holding the degree of BA (Interpreting and Translating) or a Graduate Diploma of Interpreting; and
- is typically a member of the Australian Institute of Interpreters and Translators (AUSIT), and thus adheres to AUSIT's Code of Ethics.

These credentials enable the professional interpreter to provide independent, unbiased, confidential, complete and accurate interpreting for both the medical practitioner and the patient.

In Australia, NAATI accredits interpreters and translators to meet standards at the paraprofessional, Australian professional and international levels. The recommended level for medical interpreting

is the Australian *professional level.* (See Appendix 1 for details of the accreditation levels of interpreters.)

How do you find medical interpreters?

Interpreters can be self-employed, work for interpreting and translating agencies, or can be employed by government departments and hospitals. Some interpreters specialise in the area of health interpreting with most of their time being spent interpreting for medical consultations. Other interpreters may work across a range of areas including not only health but also the law, welfare and immigration. The Interpreters' Department in your hospital is probably the first place to contact if you need an interpreter; other ways of finding interpreters are listed below.

- NAATI publishes an annual NAATI directory which lists accredited interpreters throughout Australia who wish their names to be published and who are available for assignments. Ask your librarian to acquire a copy of the NAATI Directory of Accredited and Recognised Practitioners of Interpreting and Translation. It is available in book form, as a CD, or on diskette. It can also be located on the Internet. The address is: <http://people.enternet.com.au/~naati/>.
- AUSIT publishes its Directory of Members located throughout Australia, again of those who wish their names to be published. Ask your librarian to acquire a copy via the email address: <europatrans@msn.com>.
- TIS, the 24-hour Translating and Interpreting Service, is listed in the front pages of the Telstra *White Pages*. This service is funded by the Commonwealth Government. Interpreting can be done over the telephone throughout Australia, or in person in certain States and Territories.
- State government agencies provide interpreter services. For example, in Victoria:
  - CHIS (The Central Health Interpreter Service), 24 hours per day, 7/288 Mount Alexander Road, Ascot Vale, 3032, tel. (03) 9370 1222.
  - VITS (Victorian Interpreting and Translating Services), 1st Floor, 371 Spencer Street, Melbourne, 3000, tel. (03) 9280 1955.
- Consult the yellow pages of the telephone directories under the heading(s) 'Interpreters' and 'Translations'.

Which language?

Usually a patient, or someone known to the patient, can let you know which language the non-English speaking patient speaks so that the right interpreter can be booked for the consultation. Most Australian States have issued an 'Interpreter Card' to non-English speaking immigrants. The patient should produce the card, which has his or her required language written on the back.

However, there are some dialects that are not so readily intelligible to speakers of the same language and must be identified. For example, if the patient speaks Chinese, it is imperative to establish what this means. Does the patient speak Mandarin, Cantonese, Hakka, Hokkien, Teo Chiew or another variety? It could be a waste of money and everyone's time if a Mandarin interpreter is booked for a patient who is a Cantonese speaker.

If someone says that a patient speaks *Yugoslav*, you will need to establish what this means. Linguistically there is no such language, so establish whether the patient needs a Bosnian, Croatian or Serbian-speaking interpreter or an interpreter who speaks another language. An *Arabic*-speaking patient may need an interpreter who is familiar with his or her Arabic dialect, for example, Egyptian or Lebanese.

Just because a non-English speaking person has come from a particular overseas country doesn't mean that that person speaks the dominant language of that country. The front pages of the Telstra telephone directory and professionally produced pamphlets available from the Interpreters' Department of a hospital can help you identify languages.

There are numerous *Australian Aboriginal languages and dialects*. They are classified by NAATI in the category of *rare* languages. This means that professional accreditation as an interpreter is not normally available through the standard methods of accreditation. *Pitjantjatjara*, which has a relatively large number of speakers, has paraprofessional interpreters, as do some other Australian Aboriginal languages and dialects; but other *rare* languages have NAATI Recognised Interpreters.

While many patients may have been in Australia for more than 30 years, their command of English may only be strong enough to exchange greetings, or to get by in telling how old their children are, what their occupation is and where they live. Often it is not of a high enough level for them to be able to understand all that you say, or for them to describe their symptoms or tell their medical history. A medical interpreter is needed to help you get accurate information

from your patient, even when the patient does speak and understand a little English. Sometimes the interpreter will standardise the non-standard English of the patient because, for example, the patient switches languages.

Listening demands on the interpreter

In some circumstances the interpreter may need to sit or stand close to the patient to be able to hear and understand. The patient's deteriorated voice volume or quality, or breathing difficulties, may make it difficult for the interpreter to hear and understand what the patient says. Sometimes these physical conditions, together with a dialect which is not so familiar, can tax the interpreter, who may need to strain to understand the patient. Not everybody speaks grammatically all the time and this too poses a challenge for the interpreter. Patients with limited education may speak a non-standard version of their language which the interpreter then has to decide whether to convey to you in a non-standard form or in standard English.

INTERPRETER:	my mo my father's mother had this condition (*seeks clarification from Italian patient in Italian*)
PATIENT:	e uno mio FRAtello
INTERPRETER:	ME and ONE of my brothers has it but the...specialist told my daughter that SHE would not HAVE this problem
PATIENT:	and to my other brother nothingk
INTERPRETER:	and to my other two + my other brothers don't have it either
DOCTOR:	okay

(Interpreted consultation with female Italian-speaking patient)

(Note: see the list of conventions for presentation of authentic spoken language in the front of this book.) This excerpt is from a consultation in which the patient's listening comprehension was such that while she could understand some spoken English, her own spoken English was non-standard. It was strongly influenced by her first language as well as her own communicative strategies which were early stages of natural second language acquisition but which had fossilised. The interpreter had been straining to make sense of the patient's non-standard English, to hear her weak voice quality (symptomatic of her illness), and understand her language mix. These complications really challenged the interpreter to provide a standard variety of English for the doctor. This was, however, characteristic of the patient's language.

Briefing the interpreter

It is part of AUSIT's Code of Ethics concerning their competence that interpreters and translators establish beforehand what will be required of them in a forthcoming assignment, and then make the necessary preparation. So do not be surprised if interpreters contact you to be briefed. They really appreciate being prepared in advance so that they can perform their work well for you and your patient. In summary, the interpreter needs to know:

WHO will be present at the consultation?
WHERE will the consultation be held?
WHEN will the consultation be held and for how long?
WHAT is the patient's condition?
WHAT do you intend to do?
WHAT can the interpreter tell you about the patient's language and culture?
HOW is the consultation to be interpreted—by consecutive or simultaneous mode?

You can efficiently brief the interpreter, and also find out from them what you need to know, if you use this checklist before each interpreted consultation (see Appendix 3 for a photocopiable version):

- the type of medical condition;
- whether this is an initial or a follow-up consultation;
- what you hope to achieve from the consultation;
- the procedures you expect to carry out;
- whether you will be undertaking a physical examination of the patient;
- if you will be reporting results, e.g. x-ray or pathology;
- whether bad news will need to be given to the patient;

- if you anticipate any difficulties or complications;
- the duration of the consultation;
- who will be present at the consultation;
- whether you expect any sight translation of documents, for example consent forms;
- whether the circumstances require consecutive or simultaneous interpreting;
- the pronunciation of names;
- whether you need cultural background information;
- anything else you think may help the interpreter to prepare; and
- confirm the date, time and place of the consultation.

If you are unsure about the pronunciation of the interpreter's name and/or the patient's name, ask the interpreter how to pronounce them and write a note for yourself with the spelling pronunciation (i.e. transliteration) of the names.

If there is some cultural item in the patient's background that you would like to understand better, raise the matter with the interpreter during the briefing. For example, during Ramadan will a patient still take prescribed medication?

ACTIVITY 1

Think of a non-English speaking patient whom you expect to see within the week, or one whom you saw recently without having briefed an interpreter.

Read the following dialogue and identify those salient items you ought to share with the interpreter to make his or her work more effective. (If you are working in a small group, allocate roles and act out your answers, keeping them as close to reality as possible.)

Scenario: A sample briefing session

The medical practitioner is sitting at his or her desk writing up reports when the telephone rings. An interpreter with whom you have worked before is phoning to seek a briefing.

DOCTOR: (*answers telephone and identifies self*)

INTERPRETER (*identifies self*) Hello, I'm _____, one of the hospital interpreters.

DOCTOR: Oh hello, _____.

INTERPRETER: I'm booked to interpret for you and one of your patients, Mr/s _____, next Thursday at 9.30 am. I haven't met Mr/s _____ before. Would you mind briefing me about this consultation because I'd like to be prepared.

At this point also check the pronunciation of the interpreter's name if you are unsure.

DOCTOR: Yes, certainly, I'm glad you phoned. Firstly though, how do you pronounce her name?

INTERPRETER: Mr/s _____

DOCTOR: Mr/s _____ (*writes name*) Mr/s _____ (*reads name aloud*)

INTERPRETER: (*corrects or gives approval of pronunciation attempts*)

DOCTOR: (*now, state patient's type of medical condition(s); the procedures you expect to follow; any expected difficulties during the consultation; if others will be present. Use the briefing checklist*)

INTERPRETER: How long will this consultation take?

DOCTOR: I expect the consultation will take about ___ minutes.
(*raise any other matters, e.g. cultural issues*)
Mr/s _____knows his/her way to our clinic/department.
So we'll see you in the _____ clinic/department next _____ at _____.

INTERPRETER: Right.

DOCTOR: Thanks very much.

INTERPRETER: It's a pleasure.

DOCTOR: 'Bye for now.

INTERPRETER: Goodbye.

Remember that the interpreter needs a schematic overview of the forthcoming consultation, because interpreters need to have a notional understanding of what to expect. They do not like going into a situation unprepared. Their preparation may include, for example, checking on particular medical terminology or finding out about particular forms that may need to be sight translated. Time spent briefing the interpreter is time well spent, because it establishes or reinforces a good rapport between yourself and the interpreter and enables the interpreter to know in advance what to expect and what to do. Also, it is more efficient and less intrusive when you do not have to brief the interpreter in the presence of the patient.

Problems about briefing may occur because nurses or administrative staff book the interpreter and the doctor is left out of the process. To improve your effectiveness:

ACTIVITY 2

- Find out who books interpreters at your place of work.
- How can they help you to brief the interpreter in advance of the consultation?

Greetings and introductions

Very often the patient and interpreter meet in the waiting room before the consultation. Sometimes you and the patient will already be acquainted, perhaps you and the interpreter will have worked together before. At other times you are all new to each other.

First greet the patient and introduce yourself. Don't assume that a new patient knows who you are. The interpreter may then in turn introduce himself or herself and then introduce the patient to you. Occasionally you may introduce the interpreter to the patient.

Remembering names

Address the interpreter by the name he or she gives you. In most cases it will be the interpreter's given name. Remember that you will have made a note for yourself about the pronunciation of the patient's and/or the interpreter's name during the briefing session with the interpreter.

Once you've come to know your patient fairly well, you may find that you agree to use the patient's given name. Of course, some people will then want to address *you* by *your* given name.

Seating or positioning arrangements

Once you have all met, exchanged greetings and been introduced, invite the patient and interpreter to each take a seat or move into the positions needed for you to conduct the consultation. It is at this point that the interpreter may suggest how and where you each sit. Follow the advice of the interpreter who will want to be able to see everybody easily.

Consider the positioning of the patient, the interpreter and yourself in relation to each other—not just during the conversational parts of the consultation, but also during the physical examination.

Figure 1 is an example of how *not* to arrange the seating, while figures 2–4 indicate different ways of positioning the participants to accommodate all three people's communicative needs.

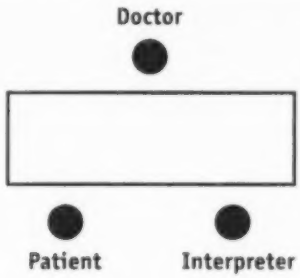

FIGURE 1 unsuitable seating arrangement

In this position the doctor is in a dominant position, sitting directly opposite the patient and interpreter. The interpreter sits beside the patient and loses his or her independent role. The interpreter cannot easily see the patient.

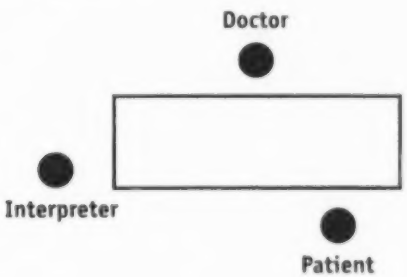

FIGURE 2 preferable seating arrangement

In this setting the interpreter can easily see both the doctor and the patient.

AUSLAN: Australian Sign Language

For Deaf patients it is also very important to follow the AUSLAN interpreter's advice about where each person should be positioned to ensure effective communication during the consultation.

During the physical examination there may be constraints about where the interpreter is located because of the fixed arrangement of the furniture or because of the sex of the interpreter.

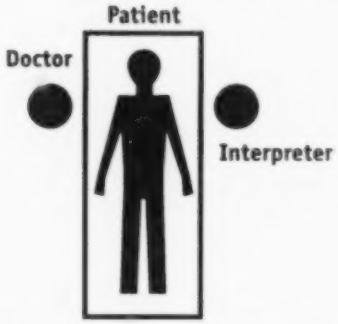

FIGURE 3
Preferable arrangement for interpreting during physical examination

This would be a preferred arrangement: all participants can see each other.

FIGURE 4
Alternative arrangement for interpreting during physical examination

This arrangement, with the interpreter at the foot of the bed, also enables all participants to see each other. The doctor and interpreter can swap positions if the doctor needs to attend to the patient's feet or legs.

It is important that a female or male interpreter is booked to meet the patient's preferences wherever possible. If necessary, curtains can be drawn between the patient and interpreter so that they see just each other's head during the physical examination. Or, the interpreter can assure the patient (and let the doctor know) that the interpreter will avert his or her eyes during the physical examination.

If a relative, friend or nurse is present, this person may need to be invited to sit in an observer's place. If there are two people simultaneously consulting the medical practitioner, then the interpreter still needs to see both the couple and the doctor.

Imagine you have exchanged greetings, introduced each other, and sat down. Now work through the following activities, which are examples of situations you might face before the consultation gets underway.

ACTIVITY 3

You need to physically examine a female patient who is of a Muslim background but the only available interpreter of her dialect is a qualified male interpreter. How would you manage this situation?

ACTIVITY 4

Your non-English speaking obstetric patient is accompanied in the consultation by her English-speaking husband. What would you do to meet the communication needs?

ACTIVITY 5

Your patient has advised the booking clerk that he or she doesn't need an interpreter. You then find the patient's command of English to be so minimal that you cannot communicate with the patient without an interpreter. What do you do?

The contract

Professional interpreters must meet rigorous standards which include interpreting everything that is said accurately, being impartial and maintaining confidentiality.

Before the consultation begins, an interpreter may want to declare his or her role and ethical obligations. (This applies particularly to an interpreter who is not an employee of the hospital or the medical centre, but who has been hired to interpret for the consultation.)

In some countries, interpreters are used as patient advocates or are asked by medical staff to take a patient's history. Fortunately this is not the case in Australia, but different people may still have different expectations of the role of the interpreter. That stage of the interpreted medical consultation called the 'contract' (a term borrowed from psychology) allows the interpreter to clarify, for the doctor, the patient and any others present, exactly what the ethical boundaries of the interpreter are.

Explaining the contract

After the introductions and greetings, you could immediately invite the visiting interpreter to declare the contract, for example, by saying

> Is there anything you would like to say before we begin?

You may find that the interpreter takes the initiative and declares the contract at the outset. For example:

INTERPRETER: Dr [X] .hh I didn't have a chance to speak to you just
then in the corridor
.hh I just want to briefly explain my role
that I'll be interpreting for you today
and everything said would be confidential and I'll be
impartial
and I'm just interpreting what you say to Mrs [Y] and
vice versa

(Cantonese–English interpreter)

In some circumstances, the interpreter will tell you the terms of his or her contract—concerning completeness, accuracy, impartiality and confidentiality—during the briefing session before the consultation.

The interpreter may also tell the patient the same information, for example, in the waiting room before they enter the consulting room to meet with you.

If the briefing session has *not* included these features of the contract, then allow the visiting interpreter to declare his or her role at the outset.

Invite the interpreter to say how he or she expects to interpret for you and your patient.

Remember that since everything is said twice in a fully interpreted medical consultation, you and your patient will take turns to hear the same thing said in your respective languages.

INTERPRETER: I've just explained to Mr X that er as an interpreter I must interpret everything .hhh and if there's anything that either you or Mr X ah would not like me to interpret .hhh then you should not say it

DOCTOR: okay

INTERPRETER: thank you

(Interpreted consultation with a Serbian-speaking patient)

ACTIVITY 6 List some expressions you can use to invite the interpreter to say how he or she will interpret for you and your patient.

In some circumstances the interpreter will reassure the patient at the end of the consultation that strict confidentiality will be maintained. The interpreter will tell you if he or she has expressed this reassurance.

Ethical components of the contract

According to the AUSIT Code of Ethics for Interpreters and Translators, the acceptance of an assignment by an interpreter is an implicit declaration of that professional's competence and constitutes a contract (oral or written). The main ethical features of this contract are:

- completeness;
- accuracy;
- impartiality; and
- confidentiality.

Expect everything to be interpreted

Professional interpreters do not interpret in the popular sense of explaining or construing what the speaker says. Rather, they remain neutral and *relay* what the speakers say. And they will relay completely everything that is said by all speakers. This includes derogatory or vulgar comments. You should also expect the interpreter to relay the non-verbal communication of participants. Interpreters are even expected to convey untruths if a participant utters them. The interpreter is not the origin of the message but the one who relays it.

Expect accurate interpreting

Professional interpreters do not alter, add to or omit what speakers say or sign. If they make a slip of the tongue or a mistake they rectify their mistake promptly. If what a speaker says is not fully audible or unclear in its content, then expect the interpreter to ask for a repetition, rephrasing or explanation. He or she will let the other person know that a clarification is being sought, so as to keep them aware of what is happening at this point in the flow of talk. For example, the interpreter may say to the doctor, 'I've just clarified with Mr Christopoulos whether he was referring to his wife or to his daughter'. Or the interpreter may ask the doctor to clarify the meaning of a medical term which was not referred to in the briefing session. At this point the interpreter would let the patient know that clarification was being sought from the doctor about a medical term. If speakers overlap in what they have to say, the interpreter may ask one to pause so that the interpreting can proceed in an orderly manner and that everything that is said is being relayed in the other language, each speaker thus being enabled to take their turn.

Expect impartiality

Professional interpreters can't be held responsible for what the patient or the medical practitioner say because interpreters are required to maintain a professional detachment as they relay what the doctor and patient say to each other. The interpreters are not to give an opinion, whether they are asked or not, on the subject matter or on persons in relation to an assignment. Interpreters are expected to disclose any conflict of interest, including performing assignments for relatives or friends.

Expect full confidentiality

Interpreters may not disclose the content of any interpreting assignment, so both patient and medical practitioner should feel assured that the interpreter will maintain strict confidentiality about what has been said or signed during a medical consultation.

ACTIVITY 7

An agitated patient who speaks a mainly non-standard dialect of her language with a rasping voice and fluctuating volume asks the interpreter for an opinion about the patient's way of speaking. The interpreter stops interpreting and tells you that the patient has just asked the interpreter for this opinion. What do you say to the interpreter?

Addressing the patient

Even in interpreted medical consultations, the conversation is still between you and your patient, so

- talk directly to your patient;
- address your patient by his or her name;
- look at your patient as you speak to him or her;
- watch their body language for additional clues about their responses; and
- use the interpreter's voice to relay what you say.

Do not talk to the interpreter *about the patient*, by saying, for example, 'Does she smoke?' Instead, talk directly *to the patient*, for example, 'Do you smoke?'

Maintain eye contact appropriately

When we talk to someone, we usually look at that person while we speak. So, where do you look when the next person to speak after you will be the interpreter, yet you are talking to the patient?

In most cases, look at the patient, because you are addressing him or her and relying on the interpreter to convey the message. For some people of particular cultural backgrounds, however, eye contact is not valued in the same way as it is for English-speaking peoples. If you are in doubt about using eye contact or expecting reciprocal eye contact, for example, with some Indigenous Australians, seek advice from your interpreter during the briefing session before the consultation.

It's preferable for everybody to see each other all the time, but where do you direct your gaze when you speak and when you listen? Look at

- the patient when you speak to the patient;
- the patient and the interpreter when the interpreter relays what you say;

BEST COPY AVAILABLE

- the patient when the patient speaks; and
- the interpreter and the patient when the interpreter relays what the patient says to you.

Speak directly to your patient

Don't be surprised if the interpreter encourages both you and your patient to address each other directly. This means that you don't need to look at the interpreter but at the patient as you speak. If you look in the direction of your patient and talk to your patient, you won't need to waste time by asking the interpreter each time you speak to interpret by saying, for example, 'Ask Mrs X when she first felt the pain'; or 'Tell Mr Y I'd like to examine him now'. The interpreter is there to convey what you say. So instead say, 'Mrs X, when did you first feel the pain?' or 'Mr Y, I'd like to examine you now'.

Follow the role of speaking directly to your non-English speaking patient. Use the voice of the interpreter who relays what you say. There is no need to speak directly to the interpreter once the consultation gets underway, unless there is need for clarification. You don't need to request the interpreter to ask or tell the patient what you want to say. The interpreter will relay everything that you say. It is implied in their purpose for being present, if they haven't already declared it in the contract stage.

Speak to your non-English speaking patient in the same way you would speak to your English-speaking patient.

Pronouns

In linguistic terms, the English language has two particular grammatical categories called person and number. We use person to indicate who the speaker is, who the listener is and who or what is being talked about. The system of pronouns helps us to do this. We use the first, second and third persons in their *singular* and *plural* forms (the category of number). You can make efficient use of your time and appropriate use of the interpreter's service by selecting your pronouns appropriately. Appendix 2, 'The pronoun system in English', provides tables to illustrate the main pronouns of English according to person, number, and their grammatical function within the sentence.

First person pronouns

Pronouns are used instead of nouns. The first person pronoun indicates who is talking. When one person is speaking, the singular form *I* is used in English. The plural form *we* indicates that the 'singular' speaker and one or more others are included. The use of *we* as an inclusive expression can be helpful in encouraging a team effort, to let the patient know that the patient, the medical, nursing and relevant paramedical staff and/or relatives will work as a team for the patient's benefit. However, the use of *we* can also be perceived as patronising, since the patient is really subject to the doctor's directions in many medical circumstances. The expression *we* can also be perceived as being impersonal, reflecting an institution's will, typically the hospital's, and not that of the person of the patient. There are, of course, positive circumstances in which you can identify yourself with an organisation or unit and use the plural pronoun *we*.

If you talk directly to the patient and if the patient has been advised to talk directly to you, then when the following type of exchange occurs you know that it's the patient and not the interpreter who is in pain.

DOCTOR: (*addressing patient*)
what seems to be the trouble

INTERPRETER: (*relays in Greek what doctor asked*)

PATIENT: (*replies in own language*)

INTERPRETER: I have pains in my tummy

(Interpreted consultation with Greek-speaking patient)

Second person pronouns

The second person pronouns identify who is being addressed. If you talk directly to your patient, the interpreter will know that the pronoun *you* refers to the patient and will relay it appropriately. For different languages, the interpreter may need to use the formal pronoun as the second person pronoun to maintain appropriate professional distance between you and your patient. Informal variants of the second person pronoun are appropriate for children or can be used only after your patient has suggested that you or the interpreter use a less formal pronoun.

The word for the second person pronoun in English is *you*, whether it is in the singular or plural form and whether it is the subject or the object of the sentence. The possessive forms are *your* and *yours*. The reflexive pronoun, *yourself*, has a plural form *yourselves*.

Address your patient by using the patient's name and the pronoun *you*. By using the pronoun *you* and its variant when speaking to your patient, time is saved and you are using the normal conventions of speaking in English.

Third person pronouns

The third person pronouns refer to the person(s) or item(s) being talked about. The singular pronouns indicate the sex of the person. The third person plural pronoun, *they*, and its variants (see Appendix 2) are used in spoken language, and to varying degrees in written language to avoid identifying the person being spoken about, since the third person singular pronouns of English identify that person's sex. For example, *they* is often used in this book to avoid writing *he* or *she*, especially when the sex of the person being referred to is not relevant.

Roles

Even though the medical practitioner is discouraged from using the third person pronouns *he, she, him, her*, and so on to avoid talking *about the patient* in their presence, and is instead encouraged to talk *to the patient* by using the second person pronoun *you*, the same does not always apply to the patient.

Sometimes the interpreter uses the third person—*he, she*, or *the doctor*—when interpreting for the doctor because the patient could become confused about which person is actually the doctor if the interpreter says, 'I…'. For example:

'The doctor says…'

'The doctor asks…'

'He wants to know…'

'She asks if you…'

It is the interpreter who determines whether the patient will become confused about what roles each person has in the consultation. The interpreter makes the roles very clear so that the patient knows who the doctor is and who the interpreter is. Nonetheless, while interpreting what the patient says to you, the interpreter will normally use the first person pronouns.

Choice of pronoun reflects your attitude

There is no necessary direct translation of English pronouns into other languages, but the interpreter will convey into the patient's language the sense of what you say in English. It is therefore important to understand that your use of pronouns will reveal a lot about your social distance and attitude of care towards both your patient and the services of the interpreter.

Names

Before the consultation, during the briefing session with the interpreter, is the best time to clarify how to pronounce both the patient's and the interpreter's names and also to obtain advice about which name should be used. If you learn of other names, for example, of other relatives of the patient, or unfamiliar place names, during the consultation it could be worthwhile jotting them down in your notes. You could ask for the spelling of the names, explaining as you write them down that you aren't familiar with them and want to get them right.

It's important to understand the various cultural attitudes to names, for example: that some married women maintain their maiden name; that some surnames are given first; that some given names are not mentioned; that the names of some deceased people are not mentioned. If you are in doubt, ask the interpreter in advance. Many people don't like having their names anglicised. Neither do they like being called by simplified versions of their name, or by names substituted by others who have trouble pronouncing them. A nickname may be a person's dominant name. Respect for non-English speaking patients is best shown by using their formal names until requested (by the patient) to do otherwise. Children and teenagers would be addressed by their given name and occasionally by appropriate nicknames.

ACTIVITY 8

Suggest some appropriate and inappropriate circumstances for the use of the inclusive pronoun *we* when addressing patients. Specify the patient's age, sex, medical condition and circumstances.

ACTIVITY 9

When requiring patients to do something, for example during the physical examination, consider how to use personal pronouns. Which of the following expressions are appropriate for which style of interpersonal communication? What do each of these interpersonal expressions require the interpreter to convey to the non-English speaking patient?

Expression (request made by doctor)	**Interpersonal style**
a Let's have a look in your ear.	
b I want you to turn your head to the left for me.	
c I want you to turn your head to the left so I can have a look in your ear.	
d Now to the left.	

ACTIVITY 10

How would you improve the English language of this segment of a consultation to

- establish better rapport with the non-English speaking patient, and
- use the interpreter's services more efficiently?

DOCTOR: when she says she lost consciousness what did she mean

INTERPRETER: (*interprets for doctor*)

PATIENT: (*replies in her language*)

INTERPRETER: (*interprets for patient*)

I don't remember anything about it

DOCTOR: how long for

INTERPRETER: (*interprets for doctor*)

PATIENT: (*replies in her language*)

INTERPRETER: I don't know

DOCTOR: does she remember falling

INTERPRETER:	(*interprets for doctor*)
PATIENT:	yeah
INTERPRETER:	yes
DOCTOR:	how old is Mrs...
PATIENT:	(*understands the question in English and replies in her language*)
INTERPRETER:	seventy-one
DOCTOR:	when she was lying on the floor she said she couldn't walk was there any other problems that she had at that time that she noticed
INTERPRETER:	(*interprets for doctor*)
PATIENT:	(*gives one-word reply*)
INTERPRETER:	no
PATIENT:	(*offers information that contradicts her immediately prior answer in her language*)
INTERPRETER:	I just my leg my leg was hurting and I couldn't see out of that eye
DOCTOR:	was she sick in the tummy at that stage
INTERPRETER:	(*interprets for doctor*)
PATIENT:	(*nods head to indicate 'no' and purses lips to make unvocalised 'no'. Points to her eye*)
INTERPRETER:	no
PATIENT:	(*partially repeats in her language what she just said that contradicted her earlier reply of 'no'*)
INTERPRETER:	just my eye which I couldn't see from
DOCTOR:	was there any numbness or tingling in her hands or legs
INTERPRETER:	(*interprets for doctor*)
PATIENT:	just my eye which I couldn't see out of
DOCTOR:	any trouble hearing...or speaking
INTERPRETER:	(*interprets for doctor*)
PATIENT:	(*replies in her language*)
INTERPRETER:	I don't think so

(Interpreted consultation with Italian-speaking female patient)

Turns at talk

In medical consultations, both the medical practitioner and patient take turns at speaking. Sometimes the turns are short, sometimes they take longer. However, in *interpreted* medical consultations, every turn must be spoken twice—once by the speaker (the doctor or the patient), and again by the interpreter in the other language. In ideal circumstances, the interpreter should have the same number of turns at talk as both the patient and the doctor, not to talk but to interpret.

Types of turns

One person initiates a turn and the other responds. These turns can occur in pairs, such as: greetings; questions and answers; a proffered topic and a corresponding comment; a formulation and decision; an observation and decision. The latter pairs can be used as checking strategies. Some pairs occur as directions and responses: typically, the medical practitioner requests, tells or directs the patient to do or tell something and the patient responds verbally or complies non-verbally. A different type of turn is one which follows up what was said and is in the form of a brief acknowledgment such as a 'yes', 'mm', 'good'. Some other brief turns, usually uttered by the medical practitioner, can be management turns, for example, 'right', 'now', 'okay'. They tend to be said a little more loudly and with rhetorical pausing. They are used to indicate the start and sometimes the end of a stage or segment of the consultation.

Length of turns

Lengthy turns at talk may be taken by the medical practitioner when explaining the findings from the diagnosis (see section on the exposition). Lengthy turns at talk are typically made by the patient when recounting the events surrounding the onset of the medical condition. Short turns can be used by the patient when answering closed questions asked by the medical practitioner who seeks specific information (see 'Taking the medical history').

Even though a patient may take a lengthy turn at talk when, for example, recounting an event, the interpreter will interpret what the patient says, segment by segment, and not wait until the patient has finished speaking.

Modes of interpreting

Typically in medical consultations the mode of interpreting is *consecutive*. That is, one person speaks, then the interpreter renders what was just said into the other language. The interpreter follows consecutively and has his or her turn (not at talking but at interpreting). In psychiatric consultations, it may be necessary for the interpreter to use the *simultaneous* mode of interpreting.

Simultaneous interpreting allows the interpreter to 'shadow', that is, interpret almost immediately what the patient is saying. Because a psychiatric patient may not necessarily follow the usual cooperative rules of turn taking, the interpreter can provide optimal service by speaking almost simultaneously with the patient. The psychiatrist can then follow immediately what the patient says. Depending on the circumstances, the seating position of the interpreter may differ from the typical position used for the consecutive mode of interpreting.

Occasionally the simultaneous mode of interpreting can occur in regular medical consultations, for example when the patient is telling a narrative or recounting an experience that takes a while to tell. The simultaneous mode is normally only used when the patient speaks, not when the medical practitioner speaks. The simultaneous mode is used in conference interpreting when listeners use earpieces or headsets to hear the speaker's talk interpreted into their language.

Clearly interpreting is a complex skill that requires a high level of concentration—but there are several strategies that you, as a medical practitioner, can use to enable the communication to be effective.

These strategies include:

- **planning ahead what you want to say;**
- **speaking grammatically;**
- **not talking too quickly;**
- **not overusing slang or colloquialisms; and**
- **pausing after each turn so that what you have said can be interpreted.**

BEST COPY AVAILABLE

Plan ahead

Before you begin the consultation, and during the consultation, you have in mind your goals and objectives for it. You have frameworks for seeking information on particular medical conditions and for making diagnoses, and you know the steps and stages of your typical consultations. Since you have all this procedural knowledge and experience, it is then worthwhile planning how to implement it at the level of turn taking. This is best done not only by listening carefully to the interpreter and the patient, and watching the patient's non-verbal communication, but by planning what you want to say.

Generally, when we speak, we don't speak grammatically, in the way we would write grammatically in a letter or in formal written communication. For example, we leave things out which could be understood from what was said earlier in the conversation or remembered from a previous consultation. Sometimes we forget something and search for a word, or substitute an expression that is close to what we intended. Sometimes we make grammatical slips, but do not correct ourselves because we believe the sense of what we have said is understood. Other times we hesitate, and/or repeat ourselves. There are various reasons for these normal ways of speaking, as distinct from the 'ideal' mode of speech. Sometimes we have to speak aloud to formulate our thoughts (rather like scribbling a draft in written language). You can help the interpreter, however, by planning your thoughts and expressions and using those that would best express your intentions. If you know what you want to say, usually the syntax and vocabulary follow.

Overlapping

Sometimes more than one person speaks at a time and this can be challenging or even make it impossible for the interpreter to continue. The interpreter will therefore signal by using a gesture or an actual interruption to ask one of the speakers to let the interpreter finish relaying what has just been said.

ACTIVITY 11 What would you do in the case of wanting to say something very pertinent and important at a particular point in the consultation, when the patient and interpreter are talking and you can't get a word in, and you aren't sure what they're saying?

ACTIVITY 12

Reflect on your own use of language to check whether you use any colloquial expressions or slang in your consultations with English-speaking patients that you might also use in your consultations with non-English speaking patients? Could any of these possibly pose problems for the interpreter's efficiency in interpreting for you?

Taking the medical history

To take a case history, identify a patient's symptoms, or make a diagnosis or prognosis, you need to get information from the patient. You would normally do this by asking questions, asking the patient to tell you certain information, or offering a topic for comment. (In the video, the terms 'open' and 'closed' questions were used, but here we use their equivalent grammatical terms.)

Having in mind the importance of

- keeping your turn at talk brief, and
- planning ahead what you want to say,

use the following grammatical structures to formulate your questions and allow the interpreter to relay your question efficiently and effectively.

Types of questions

- **Yes/no questions** require only 'yes' or 'no' as an answer. For example:

Question: Are you allergic to penicillin?

Answer: No.

The yes/no question is a classic type of closed question.

- **Alternative questions** require the listener to choose between items. For example:

  Did you have these recurring bouts in 1985, 1993 and last year or just while you were overseas this year?

To answer this question the patient can choose any or all four options offered. The alternative question, sometimes called 'polar' question, is a type of closed question.

- **'Wh–' questions** are question words that usually start with 'wh–':

  who, whom, whose, what, which, when, where, how, why

Wh– questions can be closed or open questions depending on how they are used.

The following examples, taken from actual interpreted medical consultations, illustrate the main types of questions in English.

Yes/no questions

These questions require only 'yes' or 'no' as an answer.

DOCTOR: and + had you had any falls

INTERPRETER: e lei è mai caduTA

PATIENT: si sono caduto=

INTERPRETER: yes + yes I have fallen

PATIENT: =caduto a CAsa

INTERPRETER: in in my house

(Interpreted consultation with Italian-speaking female patient)

In this case the Italian-speaking patient not only answers 'yes', but also provides additional information about where she had fallen.

Alternative questions

These questions (sometimes called 'multiple choice' questions) require the listener to choose between items.

DOCTOR: is there any er HEADaches
or dizzy spells
or

INTERPRETER: da li imate glavobolje
ili vrt oglavicu
ili nesto

PATIENT: (*replies in Serbian*)

INTERPRETER: never had that in my life
never er dizziness or
headaches in my whole life

(Interpreted consultation with Serbian-speaking male patient)

In this case the doctor gave two clear options and left another option, 'or…', in case the patient had some other type of symptom or something else to say on that matter. The Serbian-speaking patient claimed never to have had either headaches or dizzy spells in all his life.

'Wh–' questions

These questions seek to identify people or things; or seek to establish information about time, place, manner or reason.

DOCTOR: how often would that happen

INTERPRETER: quante volte è successo che è caduta

PATIENT: .hhh una volta mi ricordo preciso

INTERPRETER: one + I can remember one TIme clearly

(Interpreted consultation with Italian-speaking female patient)

The doctor's question here seeks information about frequency, the number of times the patient had experienced falls.

Ranking scales

It isn't particularly useful to ask non-English speaking patients who may not have a strong educational background to rate their degree of pain on a scale of 1 to 10. They may not be experienced in completing written questionnaires, let alone transferring such questions to the spoken mode. Identifying a time when the patient felt significant pain, and asking the patient to compare his or her pain of today to that prior experience, would be a more concrete way of obtaining comparative information about the severity of the pain than requesting an abstract assessment derived from an imagined Lickert scale.

Directing the patient to tell

Another strategy for obtaining information about the patient's medical history is to direct the patient to just tell you what happened. It is best used when you expect the patient to provide a recount of incidents. The interpreter will relay your polite direction.

As noted earlier ('Turns at talk'), spoken language includes thinking aloud, repetition or paraphrasing. This can occur in the use of multiple questions in one turn at talk, which really serve as 'requests of the patient to tell'. For example:

DOCTOR: if we look at the problem of diabetes
HOW has this affected your life
what + problems have you suffered from the diabetes
aPART from the leg
any any problems

(Interpreted consultation with Vietnamese-speaking female patient)

ACTIVITY 13 How would you rephrase this doctor's turn at talk to make sure it's efficiently phrased for the interpreter to relay it?

Checking your understanding

Even though the interpreter will relay to you what the patient says, you will, from time to time, want to 'take stock' of what you have heard and have your understanding confirmed. One important strategy for checking your understanding is the *formulation* and *decision*. The formulation is used by the doctor who usually starts with the word *so* and sums up what he or she has heard thus far. The interpreter relays this to the patient who replies with the *decision*. The decision should either confirm or disconfirm what the doctor has said. The decision may be as simple as 'yes' or 'no', but sometimes the patient keeps the turn at talk and elaborates on the decision. For example:

DOCTOR:	and + did this ONLY come on when she walked
INTERPRETER:	(*interprets doctor's question in Vietnamese*)
PATIENT:	(*replies in Vietnamese*)
INTERPRETER:	yes at NIGHT and ah during the ni:ght I feel PAIN and ah .hhh in the morning sometimes I have difficulty walking and therefore I have to do some exercise
DOCTOR:	mhm (*writes notes*) so it ALso came on at NIGHTtime it also troubled you at NIGHT
INTERPRETER:	(*interprets doctor's formulation in Vietnamese*)
PATIENT:	(*provides decision and elaborates in Vietnamese*)
INTERPRETER:	uhhuh it's at NIGHT when I lie down in bed
DOCTOR:	mhm

(Interpreted consultation with Vietnamese-speaking female patient)

In the above excerpt, the doctor is seeking information about the occurrence of the pain that the patient suffers. He understands that the pain occurs when she walks, but needs to be sure that it occurs at night as well. He seeks confirmation that this is the case, not by asking another question, but by summing up what he thinks is the case in his *formulation*.

> so it ALso came on at NIGHTtime
>
> it also troubled you at NIGHT

The patient's response as a *decision* is a clear confirmation, first through the interpreter's non-verbal expression, 'uh huh', meaning 'yes'; and secondly with the statement about the pain, that 'it's at NIGHT when I lie down in bed'. The doctor shows that he accepts this confirmation of what he said by his follow-up non-verbal expression, 'mhm'.

To get the best results from your questions,

- **use *closed questions* for specific information;**
- **use *open questions* and requests to draw the patient out;**
- ***frame questions carefully* before you ask them; and**
- **use *checking strategies* to verify what you've heard.**

The medical history and physical examination stages of the consultation are dominated by information-seeking and checking strategies for the purposes of obtaining the information on which your diagnosis largely depends. Your effective planning and use of questions and checking strategies can assist the interpreter to be efficient in his or her work for you and your non-English speaking patient.

The exposition

The *exposition*,[1] or *resolution* (the term used in medical interpreting), can be regarded as the climax of the medical consultation. The exposition is the stage when you typically:

- explain your understanding of the medical problem;
- give your diagnosis;
- give your prognosis;
- suggest options for treatment;
- prescribe medication if needed; and
- establish the plan of action for the patient.

The efficacy of your examination and diagnosis depends on how well you communicate this stage of the consultation.

The strategies mentioned previously, of:

- **planning ahead what you intend to say;**
- **speaking grammatically;**
- **pausing after a turn at talk for the interpreter to interpret what you have just said;**
- **addressing your patient by name; and**
- **looking at your patient as you speak;**

are just as important during this stage of the consultation.

Because it's at this stage of the consultation that the medical practitioner typically has the most to say, it's very important to:

- chunk your information into topics and subtopics;
- select the language suitable to your patient;

1 As referred to by P. R. Myerscough & M. Ford 1996, *Talking with Patients: Keys to Good Communication*, 3rd edn, Oxford University Press, Oxford.

- make sure that your patient has understood what you have said; and
- avoid having the interpreter ask you to repeat what you have just said.

Topics and subtopics

Whether you are explaining your patient's medical condition, announcing your diagnosis or prognosis, suggesting options for treatment, prescribing medication, advising on treatment, or establishing the plan of action for your patient, you would work best with the interpreter if you deal with one topic at a time, even though various activities, medication, justifications and diagnoses are all interrelated.

If you summarise and explain your understanding of the patient's medical problem, this provides a schematic framework for you, the interpreter and the patient to relate subsequent matters of your advice on medication, treatment and a plan of action for the patient.

Chunking what you have to say into major units of information will allow you to take several turns at talk for each major topic. The following annotated excerpts present a way of managing the exposition stage using the services of an interpreter. (The excerpts in this scenario are taken from an interpreted consultation with a Serbian-speaking male patient.)

Scenario: The consultant physician's summing up

well, Mr X, the findings do conFIRM that your blood pressure is HIGH

I think the levels are + er somewhat HIGHER than we'd like

we need to work towards getting it down

This announcement—of the findings; the expression of an opinion; and a suggested goal—chunks the information into three subtopics which the interpreter can easily understand and relay to the patient. The pronoun *we* includes the medical personnel and (potentially) the patient.

When you see a SPECialist for the first time it's a bit trauMATIC and -er can can LEAD to a higher reading of course

Clarification and positive self-correction

The consultant physician acknowledges the psychological circumstances of the initial consultation and its potential impact on the patient's blood pressure level. He tries to tone down the impact of his choice of word 'trauMATIC' by using the colloquial expression 'a bit' to modify it. This is relayed to the patient who then seeks clarification via the interpreter who checks.

INTERPRETER: er you mean—er a bit—er anxious

PHYSICIAN: well do you think he's *you're* a bit anxious
you feel a bit anxious?

INTERPRETER: (*relays what physician says to patient*)

PATIENT: (*replies in Serbian*)

INTERPRETER: yes I do

PHYSICIAN: I understand I understand

INTERPRETER: (*relays what physician says to patient*)

The physician responds initially to the interpreter who is momentarily perceived to be asking the question: 'well do you think he's'. The physician then rapidly self-corrects: 'you're a bit anxious' and directs his question fully to the patient: 'you feel a bit anxious?' The repetition of 'I understand' shows that the physician takes into account the patient's acknowledgment of anxiety on this occasion and demonstrates rapport with him.

PHYSICIAN: neverthe—nevertheless—er at least er
TWO doctors now found your blood pressure to be
higher than we'd LIKE
and therefore I think we need to do some investigations
to find out if there is a CAUSE for this blood pressure

INTERPRETER: (*relays what physician says to patient*)

In this turn at talk, the physician reinforces his claim about the patient's higher-than-normal blood pressure. He emphasises the fact that *two* doctors' findings are the same and uses the first person plural pronoun 'we' to confirm the dual findings. He elaborates a little on how the goal of reducing the blood pressure might start to be achieved: 'we need to do some investigations'. This chunk of information is grammatical and logical. The hesitant use of 'nevertheless' extends the physician's expression of rapport while at the same time allowing him to pose the logic of his plan of action. This length of turn is about right for the interpreter to remember its contents and relay them efficiently.

PATIENT: (*answers physician's question*)

INTERPRETER: (*interprets what patient said in Serbian*)
yes I, I now take double the dose that I was originally
prescribed
and I take twenty milligrams in the morning and twenty
milligrams in the evening

PHYSICIAN: alright

BEST COPY AVAILABLE

The patient, via the interpreter, is a cooperative conversationalist, and in the context of the consultation implies that because he is taking double the amount of originally prescribed medication, his blood pressure has changed and needs attention.

PHYSICIAN: before we adjust your therapy any any more
I would like to do some investigation to see
.hhh if perhaps there is—er some underlying KIDney
PROBlem
or or some hormone excess that is CAUSing your blood
pressure

The physician acknowledges the patient's contribution to the discussion and advises that before 'we' (the physician and referring medical practitioner) make any changes to the medication, he wants some investigations done. The contents of this turn at talk are clearly stated for the interpreter to relay to the patient. That is, the acknowledgment of the patient's contribution to the talk is used to provide information about the plan of action (no change yet in medication); and the reasons for the recommended investigations are given.

The work of a qualified and accredited interpreter would reflect the sensitive style of the physician. His use of 'perhaps', his expression of hesitation ('er'), and the repetition of 'or', are used to tone down the potential threat which lurks in announcing the possible causes of the high blood pressure: kidney problem or hormone excess. The briefing before the consultation can help the interpreter to get a feel for the interpersonal style of the medical practitioner.

PHYSICIAN: I can assure you that the heart and your lungs are fine
that there's + there's NO er immediate danger

INTERPRETER: (*relays in Serbian what physician said*)

PATIENT: (*acknowledges in Serbian*)

INTERPRETER: (*relays in English what patient said in Serbian*)
that is how I feel

PHYSICIAN: it's something that needs attention

INTERPRETER: (*relays in Serbian what physician said*)

PATIENT: (*acknowledges in Serbian*)

INTERPRETER: (*relays in English what patient said in Serbian*)
that's okay I understand completely

PHYSICIAN: alright

In his first turn at talk in this segment of the exposition, the physician announces his other findings which, being positive, are announced as an expression of assurance. The patient confirms that he believes his heart and lungs are in a satisfactory condition. The physician nevertheless restates the major topic of the exposition (the patient's high blood pressure *needs attention*). The patient acknowledges the physician's reminder of the need to do something about the high blood pressure.

PHYSICIAN: now I'm going to order er a kidney SCAN TEST
and I'm going to order
.hhh er an examination of of the HEART
to look at the wall THICKness and the heart FUNCtion

INTERPRETER: (*relays in Serbian what physician said*)

PATIENT: (*acknowledges in Serbian*)

INTERPRETER: (*relays in English what patient said in Serbian)*
I understand

PHYSICIAN: and I'll be contacting Dr X about these er + these TESts +
um RESULTs
I'd like you to have them FIRst and then come back and
see me
the erm ONE other test that I DO want you to have is the
twenty-four hour collection of the urine + to to measure
the stress hormones

INTERPRETER: (*relays in Serbian what physician said*)

This segment of the exposition comprises the broad plan of action for the tests that the physician wants done. The physician announces the tests by type and purpose, which the patient acknowledges via the interpreter. What is to be done with the results is also made clear by the physician. He then announces a third type of test and its purpose. The chunking of this information about the tests, into two turns at talk, enables the interpreter to relay the information very effectively and the patient to follow easily.

PATIENT: (*offers information in Serbian)*

INTERPRETER: (*relays what patient said in Serbian*)
I have done before the urine analysis and er
as far as I remember it was ALWAYs okay

PHYSICIAN: I'll check with Dr X first
and then we could organise that test at the later time

INTERPRETER: (*relays in Serbian what physician said*)

The information about the urine tests were not in the letter of referral and not picked up during the history-taking stage. The patient, via the interpreter, was able to comment on the third type of test as one he had experienced with positive results on previous occasions (inasmuch as he remembered them).

PHYSICIAN: do•you have any questions you want to ask ME
or anything that that I can EXplain to you

INTERPRETER: (*relays in Serbian what physician said*)

PATIENT: (*answers in Serbian*)

INTERPRETER: (*relays what patient said in Serbian)*
I don't know whether this could have anything to do with
it
but I was involved in an accident
AND—er .hhh one of my er MUSCles here (indicates) is
DAMaged

PHYSICIAN: I think it's unlikely but perhaps we can explore that the
next time

INTERPRETER: (*relays in Serbian what physician said*)

In this segment of the exposition, the physician checks to make sure the patient has understood what has been said by inviting the patient to ask anything the physician can answer or explain. The patient takes up the invitation by checking whether an identified damaged muscle has any bearing on the diagnosis. The physician acknowledges that it is probably not relevant but doesn't dismiss the patient's concern; instead he suggests that the damaged muscle be a topic for the next consultation.

PHYSICIAN: I want you to have these TESTs in the next two weeks
and come back and see me + in two weeks

INTERPRETER: (*relays in Serbian what physician said*)

PATIENT: (*asks question in Serbian*)

INTERPRETER: (*relays what patient said in Serbian*)
when should I go there

PHYSICIAN: we'll arrange this through the office
and the secretary will give you an appointment

INTERPRETER: (*relays in Serbian what physician said*)

PHYSICIAN: okay

This final segment of the exposition has the physician summing up this stage of the consultation and, by answering the patient's question, showing how a start will be made on the action plan ('the secretary will give you an appointment').

The turns at talk are brief and straightforward to interpret. By implication, the interpreter may need to interpret for the patient (and the secretary) as he makes his appointment and works out how and where to go for the tests.

The actual conclusion to the consultation, expressions of thanks and farewells occur after the exposition. It can be during this final stage of the consultation that the medical practitioner checks that the interpreter would be available to interpret for the patient for the various appointments requested by the physician.

Summary

These sequential excerpts, quoted from an interpreted medical consultation, show how the consultant physician:

- chunked what he had to say into topics and subtopics, or equal segments (depending on the content);
- used language suitable to the patient's needs for toning down potentially alarming information (e.g. kidney problem and/or excess hormone);
- toned down appropriately one expression—'a bit trauMATIC' which could have been better phrased as 'a bit daunting' or 'anxious';
- incorporated the patient's contributions to the exposition;
- gave the patient the opportunity to ask questions or seek explorations; and
- kept his turns at talk to lengths easily processed by the interpreter, and thus avoided having the interpreter seek repetitions.

ACTIVITY 14

How do you tone down potentially threatening or unpleasant information you have to share with patients and yet get the essence of the message across?

- Would your style of speaking be modified if you used the services of an interpreter?

ACTIVITY 15

Think of a patient you have attended to recently and to whom you had to convey: a fairly involved diagnosis; choices of treatment; medication; and a plan of action. Remembering that your non-English speaking patient has to wait until what you say has been interpreted, how could you chunk your information into logical blocks of information to ensure that:

- the interpreter comprehends readily what you say;
- the patient also comprehends readily what you say; and
- you believe that your plan of action would be implemented?

Use the following table in organising your response.

Diagnosis	
Treatment choices	
Medication	
Plan of action	

ACTIVITY 16

What are some of the politeness expressions that characterise your interpersonal style of talking with non-English speaking patients?

ACTIVITY 17

Can you recall any occasions when a qualified and accredited professional interpreter asked you to clarify or repeat what you said?

- Had you thought ahead what you intended to say?
- Was there an element of fatigue in the dialogue?
- Was your grammar unnecessarily complex?
- Had you used an unusual or very colloquial expression?
- Was your turn too long?

Debriefing

Debriefing after an interpreted medical consultation doesn't occur often in busy hospitals or consulting rooms, and so debriefing segments haven't been included on the videotape. However, debriefing is regarded as an important event by interpreters, especially after participating in a very traumatic medical consultation. (In such circumstances, it is appropriate to arrange for the interpreter to be offered the debriefing services of the hospital counselling centre.)

In most cases it is better to clarify as much as possible with the patient while using the services of the interpreter. There can, however, be times when you need to seek clarification from the interpreter after the consultation, for instance on aspects to do with the patient's cultural or religious background; the patient's attitudes; or the patient's language.

Such debriefing would be between the physician and the medical interpreter. It may be in a private conversation, not in the presence of the patient or friends or relatives of the patient; or in a follow-up telephone conversation if you cannot talk together immediately after the consultation.

Patient's sociocultural and religious background

The debriefing session with the professional interpreter can help the physician understand some of the belief systems, customs, practices and cultural assumptions that a patient brought to the interpreted consultation. Any such items that were touched upon but not clear during the consultation can be checked with the qualified medical interpreter who is a bilingual/bicultural interpreter. Ask for specific and general information about social, cultural and religious practices, customs and their particular dates that may enhance your understanding of the interpreted consultation, and of the patient, for future encounters.

Attitudes

Misunderstandings, or not enough understanding, on the part of the physician may be cleared up with the interpreter during a debriefing session soon after the consultation. Even though the interpreter conveyed accurately and completely what both the patient and the physician said to each other, the physician can then check whether any of his or her attitudes and assumptions blocked the communication.

Patient's language

Even though the professional interpreter is trained to cope with differences in dialects and sociolects (e.g. language variety of social class, social groups), the particular variety of language used by the patient may not be very familiar to the interpreter.

During the debriefing, if the interpreter does not automatically volunteer the information that the patient's dialect and/or sociolect were significantly different from those of the interpreter, then it would be appropriate for the physician to ask the interpreter if he or she spoke the same dialect and/or sociolect as the patient. Differences in their vocabulary may have required circumlocutions on the part of the interpreter, rather than a single lexical equivalent.

Summary

Take the opportunity to debrief with the medical interpreter after an interpreted consultation.

- Seek clarification and/or amplification on any social, cultural, religious, historical, political, medical, bureaucratic, financial, language aspects or other points that you believe would enhance your understanding of the consultation and of your patient(s) for future reference.
- If the interpreted consultation was particularly traumatic, advise the interpreter to seek his or her own debriefing with the hospital counsellors if you can't provide the cognitive and emotional support.

Conclusion

Whether your contact with non-English speaking patients is regular or not, it is worth knowing how to work effectively with an interpreter to conduct your consultations. Remember that even though many patients may have arrived in Australia a number of years ago, they may not be proficient enough in English to understand all that you say, or to tell you all that you want to know.

The patient's Interpreter Card will tell you which language the patient speaks so that an appropriate interpreter can be booked. The Interpreters' Department in large hospitals, the Telstra *White Pages*, Interpreting and Translating Agencies listed in telephone directories, and the NAATI and AUSIT directories are all good sources for contacting interpreters.

Brief the interpreter

Whenever possible, brief the interpreter before the consultation. This will also give you a chance to get any necessary cultural background information, or even guidance on how to pronounce the patient's name. Help the interpreter to prepare by explaining the nature of the patient's medical condition, who will be present, what you plan to do during the consultation, what your goals and expectations are, and the anticipated length of the consultation.

Positioning helps

Interpreters are outstanding listeners in the interpreting context, but they may be strained by having to listen to a dialect with which they are not very familiar or to a patient whose voice quality has deteriorated or who has very little volume. In all cases it is important to make sure that the arrangements for seating or standing (when necessary) enable the interpreter to hear and see both the doctor and the patient. The interpreter can usually best advise on seating positions.

Greetings, introductions

When a new patient arrives, greet both the patient and interpreter and introduce yourself by name. Allow visiting interpreters to state the guidelines which they expect the consultation to follow. This normally means the interpreter assuring doctor and patient that they will interpret everything that is said and will maintain confidentiality.

Names and pronouns

There may be a policy at your workplace which directs how you should address patients and how you are to be addressed. Remember that for most people their identity is tied to their name. If you are in doubt, find out how patients prefer to be addressed by asking them, otherwise use their formal name. Use the 'you' pronoun. Expect the interpreter to use first person pronouns 'I', 'me', 'my', 'mine' when interpreting into English what the patient says.

Look at the patient, speak to the patient

While talking to the patient, look at the patient, not the interpreter. Speak to the patient directly. There is no need to say to the interpreter, 'Ask Mr…', or 'tell him…'. The interpreter is there to interpret immediately what is said. During the interpretation in the other language, observe the patient's non-verbal communication.

Ethical considerations

Don't expect to ask the interpreter's opinion on anything during the consultation, since the professional interpreter is not an advocate, but is present to relay the message between the doctor and the patient and vice versa. The interpreter, in abiding by the profession's code of ethics, will remain impartial, and will aim to interpret everything that is said by everybody accurately. You can expect the interpreter to maintain strict confidentiality about the consultation.

Taking turns at talk

Consultations proceed through the turns at talk of the participants. Some turns are long, some are short. Sometimes they overlap, which can be a difficulty for the interpreter who needs to hear one person speak at a time so as to be able to interpret for that person. The interpreter needs to hear all the turns and interpret them. Sometimes the patient may take a long turn, describing the onset of an illness. Rather than wait for the whole narrative or report given by the patient, the interpreter will interpret segments as the patient speaks. In psychiatric consultations, it may be suitable for the interpreter to use the simultaneous mode rather than the typical consecutive mode of interpreting.

Planning ahead

In all consultations, just speak naturally and expect the interpreter to interpret for you. It helps the interpreter if you speak grammatically and try not to 'think aloud'. For more effective communication, you will find it helps to plan ahead what you have to say while the patient and interpreter are communicating in the other language.

Questions

When you phrase your questions and 'requests to tell' grammatically, this enables the interpreter to efficiently relay what you say without having to make corrections.

Exposition

During the exposition or resolution stage of the consultation, the medical practitioner typically engages in a range of information-giving activities such as explaining his or her understanding of the medical problem; giving a diagnosis and/or a prognosis; suggesting options for treatment; prescribing medication; and establishing a plan of action for the patient.

Chunk your information, check for understanding

At this stage, it is very helpful for the interpreter, and for the patient's comprehension, if you chunk your information into topics and subtopics, select vocabulary suited to the patient's ability to understand, check that the patient has understood what you have said,

and speak without too much complexity, to avoid the interpreter having to ask you to repeat what you have said.

Debrief when necessary

Debriefing after medical consultations in busy hospitals and consulting rooms doesn't happen often. Briefing before the consultation, and clarifying unclear matters during the consultation, are the best strategies. However, if you do need further clarification about the patient's sociocultural or religious background or language variety, check with the interpreter immediately or soon after the consultation.

Non-English speaking patients constitute a substantial proportion of the population in English-speaking countries which have a history of immigration. Australia is typical of such countries and is relatively well-organised in its provision of medical interpreting services. It leads the world in its provision of a national accreditation system of interpreters and translators.

Qualified and accredited interpreters at the NAATI professional level or above are regarded as the most suitable to employ as medical interpreters, since they are expected to adhere to the AUSIT Code of Ethics. By adopting the strategies outlined in this book and its accompanying videotape for working effectively with medical interpreters, you should significantly improve your communication with your non-English speaking patients and thereby deliver the high quality medical care you have been trained to provide for all patients.

Appendix I: NAATI levels of accreditation for interpreters and translators

The NAATI (National Accreditation Authority for Translators and Interpreters) levels for Interpreters (as distinct from Translators) described below are quoted from the NAATI document, *NAATI Accreditation for Translators and Interpreters*.

Paraprofessional Interpreter

This is a paraprofessional level and represents a level of competence in interpreting and translation for the purpose of general conversations.

Paraprofessional Interpreters generally undertake the interpretation of non-specialist dialogues. Practitioners at this level are expected to proceed to the professional levels of accreditation.

Interpreter

This is the first professional level and represents the minimum level of competence for professional interpreting.

Interpreters at this level are capable of interpreting across a wide range of subjects involving dialogues at specialist consultations. They are capable of interpreting presentations by the consecutive mode. Their specialisations may include banking, the law, health, and social and community services.

Conference Interpreter

This is the advanced professional level and represents the competence to handle complex/technical/sophisticated interpreting.

Conference Interpreters practise both consecutive and simultaneous interpreting in diverse situations, including at conferences, high level negotiations, and court proceedings. Conference Interpreters operate at levels compatible with recognised international standards, and may choose to specialise in certain areas.

Conference Interpreter (Senior)

Practitioners at this senior level are Conference Interpreters with a level of excellence in their field, recognised through demonstrated extensive experience and leadership.

(National Accreditation Authority for Translators and Interpreters, n.d., *NAATI Accreditation for Translators and Interpreters* (pamphlet), p. 2)

Recognised Interpreter

> Recognition does not have equal status to accreditation, because NAATI has not had the opportunity to testify by formal assessment to a particular standard of performance. It is...intended to be an acknowledgment that, at the time of the award, the candidate has had recent and reasonably regular experience as...[an] interpreter but no level of competency is specified. Recognition is valid until such time as accreditation by testing becomes available in the particular language concerned.
>
> (National Accreditation Authority for Translators and Interpreters 1997, *NAATI Accreditation*, <http://people.enternet.com.au/~naati/PDDOCS/PDACCRED.HTM> (accessed 13 March 1998))

Recognised interpreters are mainly interpreters of languages which have a relatively small number of speakers in Australia. They include 'Aboriginal Groups'; some Chinese dialects; some languages of Australia's neighbours; and languages of some refugees to Australia. They cover more than 50 languages and dialects.

Which level to select?

- For *day-to-day work in hospitals* with non-English speaking patients, you would need the services designated at the *Interpreter* level.
- For *particularly complex interpreting*, for example, about the purchase or maintenance of a piece of medical equipment manufactured overseas, or discussion with a non-English medical specialist about a new form of treatment or diagnosis, you would find the Conference Interpreter level appropriate.
- For *medical conferences*, you would work with Conference Interpreters or Senior Conference Interpreters.
- For *rare languages* for which there is no accredited professional Interpreter, then a Paraprofessional Interpreter or Interpreter with the status of NAATI Recognition may be of assistance.

Appendix 2: The pronoun system in English

Tables 1, 2 and 3 show the first, second and third person pronouns in English respectively, in their singular and plural forms, according to their grammatical function.

TABLE 1
First person pronouns in English

'First person' = the person who is speaking

Function	Singular	Plural
subject	I	we
object	me	us
possessive adjective	my	our
possessive pronoun	mine	ours
reflexive pronoun	myself	ourselves

TABLE 2
Second person pronouns in English

'Second person' = the person being spoken to

Function	Singular	Plural
subject	you	you
object	you	you
possessive adjective	your	your
possessive pronoun	yours	yours
reflexive pronoun	yourself	yourselves

TABLE 3
Third person pronouns in English

'Third person' = the person(s) being spoken about

Function	Singular	Plural
subject	he, she, it	they
object	him, her, it	them
possessive adjectives	his, her, its	their
possessive pronouns	his, her, its	theirs
reflexive pronouns	himself herself itself	themselves

Impersonal pronouns

Occasionally the identity of the person is not important and the impersonal first person pronoun *one, one's, oneself* is used by the speaker. It can be used to refer to the speaker ironically, but it is not used frequently in Australian English. Other impersonal pronouns, such as *somebody, anybody, nobody, everybody* and their variants *someone, anyone, no one, and everyone*, can also be used to refer to unidentified 'third persons'.

Appendix 3: Briefing checklist

This checklist can be used to help you make sure you have adequately briefed the interpreter before an interpreted consultation.

Check that the briefing session with the interpreter has included information on

- **the type of medical condition** ☐
- **whether this is an initial or a follow-up consultation** ☐
- **what I hope to achieve from the consultation** ☐
- **the procedures I expect to carry out** ☐
- **whether I will be undertaking a physical examination of the patient** ☐
- **if I will be reporting results, e.g. x-ray or pathology** ☐
- **whether bad news will need to be given to the patient** ☐
- **if I anticipate any difficulties or complications** ☐
- **the duration of the consultation** ☐
- **who will be present at the consultation** ☐
- **whether I expect any sight translation of documents, for example consent forms** ☐
- **whether the circumstances require consecutive or simultaneous interpreting** ☐
- **the pronunciation of names** ☐
- **whether I need cultural background information** ☐
- **anything else I think may help the interpreter to prepare** ☐
- **confirming the date, time and place of the consultation** ☐

Suggested further reading

Australian Institute of Interpreters and Translators (AUSIT) 1996, *Code of Ethics for Interpreters and Translators*, AUSIT with National Accreditation Authority for Translators and Interpreters (NAATI), Sydney (pamphlet).

Carroll, P. 1996, 'Interpreting and translating in the Northern Territory of Australia: The situation of Aboriginal languages', *Proceedings 14th World Congress of the Fédération Internationale des Traducteurs (FIT)*, Australian Institute of Interpreters and Translators, Melbourne, pp. 475–84.

Central Health Interpreter Service (CHIS) 1997, *Competency Profile*, CHIS, Ascot Vale, Vic.

Fuller, J. H. S. & Toon, P. D. 1988, *Medical Practice in a Multicultural Society*, Appendix 1, 'Naming systems', Heinemann, Oxford.

Gentile, A., Ozolins, U. & Vasilakakos, M. 1996, *Liaison Interpreting: A Handbook*, Melbourne University Press, Melbourne.

Kondo, M. & Tebble, H. 1997, 'Intercultural communication, negotiation and interpreting', in *Conference Interpreting: Current Trends in Research*, eds Y. Gambier, D. Gile & C. Taylor, John Benjamins, Amsterdam, pp. 149–66.

Monash Medical Centre n.d., *Working Effectively with Interpreters* (pamphlet).

Myerscough, P. R. & Ford, M. 1996, *Talking with Patients: Keys to Good Communication*, 3rd edn, Oxford University Press, Oxford.

National Accreditation Authority for Translators and Interpreters 1997, *Directory of Accredited and Recognised Practitioners of Interpreting and Translation*, <http://people.enternet.com.au/~naati/pdir/1.htm> (accessed 13 March 1998).

National Accreditation Authority for Translators and Interpreters 1997, *NAATI Accreditation*, <http://people.enternet.com.au/~naati/PDDOCS/PDACCRED.HTM> (accessed 13 March 1998).

National Accreditation Authority for Translators and Interpreters, n.d., *NAATI Accreditation for Translators and Interpreters* (pamphlet).

National Health and Medical Research Council 1993, *General Guidelines for Medical Practitioners on Providing Information to Patients*, Report of Working Party of the Health Care Committee, NHMRC, Canberra.

Pauwels, A. 1995, *Cross-cultural Communication in the Health Sciences*, Macmillan, South Melbourne.

Pendleton, D. & Hasler, J. (ed.) 1983, *Doctor–Patient Communication*, Academic Press, London.

Quirk, R., Greenbaum, S., Leech, G. & Svartvik, J. 1972, *A Grammar of Contemporary English*, Longman, London.

Royal Australian College of Physicians 1992, *Ethics: A Manual for Consultant Physicians*, RACP, Sydney.

BEST COPY AVAILABLE

Taylor-Torsello, C. et al. 1997, 'Linguistics, discourse analysis and interpretation', in *Conference Interpreting: Current Trends in Research*, eds Y. Gambier, D. Gile & C. Taylor, John Benjamins, Amsterdam, pp. 167–86.

Tebble, H. 1991, 'Towards a theory of interpreting', in *CITEAAXIII: Proceedings of the 13th Conference of the Interpreter and Translator Educators' Association of Australia*, ed. P. Hellander, South Australian College of Advanced Education, pp. 54–9.

Tebble, H. 1993, 'A discourse model for dialogue interpreting', in *AUSIT: Proceedings of the First Practitioners' Seminar*, National Accreditation Authority for Translators and Interpreters, Canberra, pp. 1–26.

Tebble, H. 1993, 'Formulations and observations in professional interviews: Systems analysis', in *Proceedings of the 15th International Congress of Linguists*, vol. 3, eds A. Crochetière et al., Les Presses de L'Université Laval, Laval, Quebec, pp. 265–8.

Tebble, H. 1996, 'A discourse-based approach to community interpreter education', *Proceedings 14th World Congress of the Fédération Internationale des Traducteurs (FIT)*, Australian Institute of Interpreters and Translators, Melbourne, pp. 385–94.

Tebble, H. 1996, 'Research into tenor in medical interpreting', *Interpreting Research*, Journal of the Interpreting Research Association of Japan, vol. 6, no. 1, pp. 33–45.

When you don't speak the same language as your patient, and your patient doesn't speak English—how do you cope in a medical consultation?

Use a medical interpreter. If you work with an accredited and qualified medical interpreter, your consultation with a non-English speaking patient can then be as effective as any other. The book and videotape, Medical Interpreting: Communicating Effectively with your Patients, will show you how.

To get the best results from the services of a medical interpreter, you need an understanding of how interpreted consultations work. Strategies for working with medical interpreters are demonstrated in this book and videotape—and you'll be shown easy ways to identify and learn those strategies. Samples of authentic interpreted medical consultations between English-speaking doctors and their non-English speaking patients are used in illustrating and exploring the issues.

By watching the video in conjunction with the book—either on your own or in a group—and working through the activities, you'll come to a better understanding of key issues such as addressing the patient, managing 'turns at talk' with the interpreter and patient, and taking the medical history.